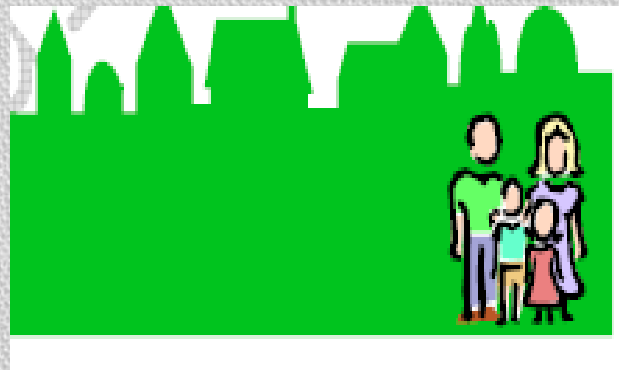




Department of Mental Health
Agency of Human Services
Child, Adolescent & Family Unit (CAFU)
**Home and Community Based
Enhanced Family Treatment
(EFT) Overview**



Agenda

- Description of waiver/EFT
- How EFT differs from FFS & ISBs
- Initial & Continued Eligibility Criteria
- Application & review process and timelines
- Review of forms
- IPCs & Budgets
- Self-Audits
- Q&A time for regions



Waiver/EFT: what is it??

- Home and Community-Based 1915(c) Children's Mental Health Waiver (since 1982)
 - *provides home and community-based services to individuals below the age of 22 who have a mental illness and are at risk of institutionalization. For the purposes of eligibility DMH/CAFU considers institutionalization to mean a JCAHO accredited inpatient psychiatric facility for children.*
- Global Commitment (2005)
- Enhanced Family Treatment (current)
- EFT/Waivers in the world of IFS



Why a waiver vs. FFS vs. ISB?



Fee-for-Service

- This is how DA bills for most eligible mental health covered services under the State Medicaid Plan
- Each DA has a cap on the total amount of FFS allowed in your children's mental health budget
- Each service type has its own rate
- Each service must be documented & billed every time it's provided



Individual Service Budget (ISB)

- DCF can purchase FFS from a DA
- Child in State's custody
- Doesn't tap into DA's FFS Cap (this is a way to expand resources to serve kids in your region – Develop a partnership with your DCF District Office!)
- Typically used for youth in an out-of-home wrap
- Allows DCF to purchase respite, crisis supports
- Simplified documentation to DMH doesn't require clinical review
- Services are billed as provided
- Must be approved by DCF Central Office

Why an EFT/ Waiver?

- EFT allows flexibility to provide an intensive wrap of services that fluctuates day-to-day
- Don't have to document & bill each service separately
- One Daily rate billed for all services
- Does not tap into FFS Cap
- Can bill for some services that aren't covered by traditional Medicaid FFS (see allowed and excluded services lists in EFT Manual)
 - Specialized evaluations
 - Consultation
 - Therapeutic Foster Care
 - Respite
- All DA Mental Health Medicaid Services MUST be on the waiver, only exception is SB6 (school-based MH)

CMS Home & Community Based Services (HCBS) Settings

- No longer defined by “what they are not”; are now defined by the nature and quality of individuals’ experiences
- HCBS Settings must*:
 - Be integrated in, and support, full access to the greater community;
 - Be selected by the individual from among setting options;
 - Ensure individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
 - Optimize autonomy and independence in making life choices; and
 - Facilitate choice regarding services and who provides them.

*these should be developmentally appropriate in application for each individual

HCBS Settings, cont.

- Provider-owned or controlled residence:
 - Setting is physically accessible to the individual
 - Setting includes provisions that the Individual*:
 - has a lease or other legally enforceable agreement providing similar protections;
 - has privacy in their unit including lockable doors, choice of roommates and freedom to furnish or decorate the unit;
 - controls his/her own schedule including access to food at any time;
 - can have visitors at any time
- DMH allows community-based residential settings for up to four (4) individuals for settings that meet these characteristics.

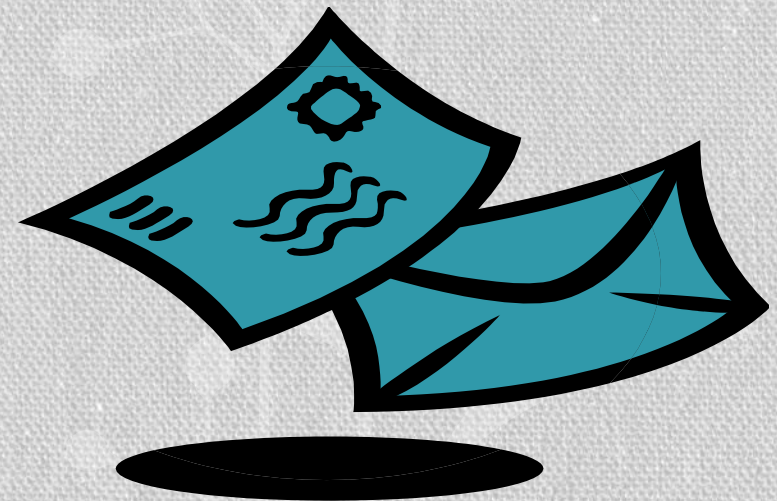
*these should be developmentally appropriate in application for each individual

What is a “matched” waiver?

- The Child Adolescent and Family Unit (CAFU) of DMH is responsible for programmatic and financial review of the Enhanced Family Treatment (waiver)
- DCF can purchase EFT services by providing the State match (State provides \$0.40 to obtain Federal \$0.60 for every Dollar – this is old thinking, but conveys gist without detailing Global Commitment Waiver)
- DCF-Matched waiver is used for children who are in State’s custody
- DCF-Matched waivers still necessitate full DMH review of EFT criteria and are overseen by DMH
- DCF District Office must review/approve locally before submitted to DMH
- DCF Central Office must review/approve once DMH has approved

EFT Process

1. Local determination of eligibility & necessity for EFT
2. DA's communicate in advance with DMH Children's Mental Health Care Manager to discuss eligibility, proposed plan, and when waiver is being considered and developed.
3. Complete Initial application packet
4. DA internal review using checklist
5. Upload to Global Scape, notify Jessica
6. DMH Technical Review
7. DMH Clinical Review & Approval/Denial
8. Signed documentation back to DA
9. Begin services and billing under EFT/Waiver
10. DA structure to review actual vs budgeted service provision



Clinical Eligibility Criteria

- The goal of the EFT services is to maintain children **in their home and/or community** or **return children to their home and/or community**.
- All **alternative resources must have been explored** and determined to be inappropriate or unavailable before an application of EFT services is submitted for consideration.
- Services included under the EFT may be provided only to persons who meet **ALL** the following criteria:

Clinical Eligibility Criteria (cont.)

1. Are a Medicaid-eligible recipient, or eligible for being “deemed” for Medicaid.
2. The services prescribed in the Individualized Plan of Care (IPC) cannot be provided by any other means

Clinical Eligibility Criteria (cont.)

3. Are children and youth who have not yet reached the age of 22 years and are still enrolled in school:

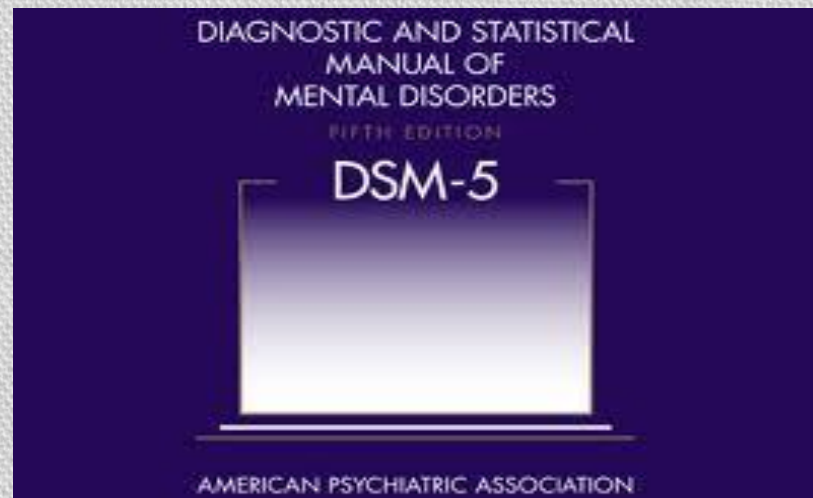
- Alternative schools, technical schools, tutoring, a GED program, and transition age students enrolled in college classes or job training can all be considered as “enrolled in school.”
- One special note: for transition age youth who have obtained their high school diploma or GED, the treatment plan should address what services or activities the youth is involved in that are helping him/her move towards independence.



Clinical Eligibility Criteria (cont.)

4. Have a primary diagnosis of mental illness

- A primary diagnosis of Autism or Conduct Disorder is an exclusionary diagnosis.
- Except in the case of a waiver needed to complete an evaluation, we would question the clinical intensity of a child that only had an adjustment disorder or ADHD.



Clinical Eligibility Criteria (cont.)

5. Are currently receiving the level of care provided in an inpatient psychiatric facility, or are likely to receive the level of care provided in an inpatient psychiatric facility if intensive services are not provided.

- The Brattleboro Retreat Hospital is Vermont's only psychiatric hospital for children, but DMH may also consider placement in a Crisis Bed or Hospital-Diversion Bed.
- A step-down from residential treatment may also be considered.
- All of the above placements must have occurred within the past six months.
- In rare situations, DMH will consider other documentation of the "risk of institutional care." Examples could include a child with multiple or frequent crisis screenings, where placement was only avoided by substantial efforts from local teams.

EFT Application Process



- EFT paperwork is due 30-days prior to the start of services for Initial and Continuation requests.
- By nature of the children served through this funding mechanism, there are times when a package of services is pulled together in response to a crisis situation and thus may not have 30-day advanced notice.
- Exceptions to this timeframe are typically granted when the DA staff person communicates the situation with their DMH Children's Mental Health Care Manager
- EFT budget periods are from January 1 – June 30 and from July 1 – December 31.

DMH Review Process

What happens once paperwork is submitted to DMH?

(**Why does it take so long?**)

- Technical review by Program Tech (Jessica Whitaker)
- Communication between DMH & DA regarding missing or clarifying elements
- Once all i's dotted & t's crossed, *then* Children's Mental Health Care Manager will review
- Follow up from the Children's Mental Health Care Manager to discuss questions regarding adequate demonstration of clinical eligibility, plan of services, etc.

DMH Review Process

- **Decisions on initial EFT applications will be made within 14 calendar days** of receipt of completed official referral.
- CAFU will notify the provider of recommended necessary changes and return the paperwork to the DA/SSA for revisions.
- A decision and/or payment for services will not begin until the paperwork is completed and a final decision is made by DMH staff.
- If the information requested to complete a **referral is not provided and the referral remains incomplete by 30 days** from receipt of application, the parent/guardian and DA/SSA will be notified that a **determination to approve or deny cannot be made**. The application will not be processed and will be returned to the DA.

Continued Eligibility

- **For an EFT renewal, the cover letter should detail:**
 - **what progress the child & family have made;**
 - **how the services continue to prevent further placements;**
 - **what progress is being made to transition the child out of EFT services; and**
 - **whether the IPC is changing and why.**

DETERMINING CONTINUED ELIGIBILITY

- Continued eligibility reviews occur on 6 month cycles for budget periods of July 1 – December 31 and January 1 – June 30.
- Thirty (30) days prior to the end date of the initial eligibility period, the DA/SSA must apply for continued eligibility.
- If the required continuing eligibility information is not submitted within 14 days of the expiration of the prior authorization or intent to apply for continued eligibility is not communicated by the DA/SSA notice of service **denial will be sent to the parent/guardian and the DA/SSA.**

DETERMINING CONTINUED ELIGIBILITY cont..

- Continuing eligibility information must include one of the following options:
 - A. If the treatment plan and budget are **remaining exactly the same**:
 - A cover letter stating the treatment plan and budget are not changing and should remain the same,
 - the signature page (with required signatures outlined above),
 - a new CBCL and
 - any new evaluations completed that would support the treatment plan remaining the same
 - B. If the treatment plan and budget **are changing**
 - A cover letter stating the changes and why, description of continued eligibility,
 - a new IPC,
 - a new budget,
 - a new signature page (with required signatures outlined above),
 - any new evaluations that support the change, and
 - a new CBCL,(See Appendix C for continued eligibility checklist).

Grievance And Appeals

- If a child is determined to be eligible for the EFT, the child and guardian will be notified of the approved plan by the providing DA/SSA.
- If the child is determined to be ineligible for the EFT, DMH will notify the child and their guardian in writing and explain how and where to file an appeal. The DA will be copied on the written ineligibility determination. The DA will identify what other Medicaid covered services the child/family is eligible to receive.
- If a child or guardian chooses to appeal the eligibility decision, the processes outlined in the **Grievance and Appeals Procedures Under Vermont's Global Commitment to Health** will be followed.
- The full document of the **Grievance and Appeals Procedures Under Vermont's Global Commitment to Health** can be found at:

<http://mentalhealth.vermont.gov/sites/dmh/files/About/2010GAManualaddeendum082312.pdf>

EFT Forms

DMH website:

<http://mentalhealth.vermont.gov/forms>



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http://mentalhealth.vermont.gov/forms

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Department-wide Forms

- Application for gubernatorial Appointment to a DMH Committee
- Personal Expense Form
- Critical Incident Reporting Requirements (June 5, 2012)
- State Electronic Critical Incident Report Form
- Transport Information Checklist for Person on Involuntary Status

Adult Mental Health Forms

- Adult Statewide Program Standing Committee Application Form
- Local System of Care Plan Form
- Application to Commence Proceedings for the Involuntary Treatment of an Individual Non-Emergency

Community Rehabilitation & Treatment (CRT) Forms:

- CRT Enrollment/Transfer/Retroll Form
- CRT Disenrollment Form
- CRT Significant Event Form
- CRT Special Services Funding Memo 2012
- CRT Special Services Funding Memorandum June 26, 2012
- CRT Special Services Funding Request Form
- CRT Special Services Dental Claim Form
- CRT Cash Payments Reporting Form

Children, Adolescent and Family Mental Health Forms

Quick Links

- Forms
- Frequently Asked Questions
- Training Opportunities
- Contact Us
- Department

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http://mentalhealth.vermont.gov/forms

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Monthly Report Form for Family Specific Request Respite Data

Special Service Funding

- CAFU Special Services Funding Request Form
- CAFU Special Services Policy and Procedure

Enhanced Family Treatment (formerly called Waiver) Forms

- Enhanced Family Treatment Manual
- Waiver Services Budget Worksheet: DMH match (FY 2012)
- Waiver Services Budget Worksheet: DCF match (FY 2012)
- Waiver Services Budget Worksheet: DMH (FY 2013)
- Waiver Services Budget Worksheet: DCF match (FY 2013)
- Waiver Suspension Form
- Waiver Notification of Termination Form
- Enhanced Family Treatment Intake Form
- EFT/Waiver and Individualized Service Budget Signature Sheet

Vermont State Hospital Forms

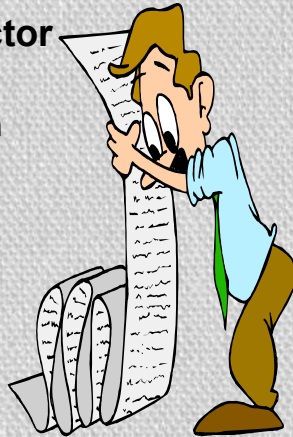
- Application to Commence Proceedings for the Involuntary Treatment of an Individual Non-Emergency
- Warrant for Immediate Examination
- Application for Emergency Examination

Technical review

Initial EFT Eligibility

Initial check list reviewed

- ☐ Submitted to DMH 30 days prior to the start date.
- ☐ Cover letter
- ☐ Signature page
 - ☐ Children's Director
 - ☐ Case Manager
 - ☐ Parent/guardian
 - ☐ Other
- ☐ Recent Assessment
- ☐ CBCL
- ☐ Intake Form
- ☐ IPC
- ☐ Budget Page
- ☐ DMH EFT Medicaid Deeming Form (if needed)



APPENDIX A	
<u>INITIAL ELIGIBILITY EFT CHECKLIST</u>	
<input type="checkbox"/> Submitted to DMH 30 days prior to the start date.	
<input type="checkbox"/> Cover letter:	Frames the clinical rationale and how the child meets the EFT eligibility. What are the child's specific clinical issues that are leading the team to apply for EFT funding? What are the child's and family's goals? In what way does the family wish to be involved in treatment? What services have already been tried? What is the long-term plan? What are the expected outcomes? How will the team know when the child and family are making progress? What other circumstances are impacting the child and the treatment? If the child is living in therapeutic foster care, where and with whom?
<input type="checkbox"/> Signature page (Appendix C) Parent/guardian signature does not need to be present on signature page if it is present on the individualized plan of care/treatment plan	<input type="checkbox"/> Children's Director Signature <input type="checkbox"/> Case Manager's Signature <input type="checkbox"/> Parent/Guardian Signature (If not present on treatment plan) <input type="checkbox"/> Other signatures as applicable – DA/SSA business manager, DCF District Director or Supervisor, other service agencies....
<input type="checkbox"/> Recent Assessment	A recent assessment should be a formal assessment done within 6 months of the EFT start date. This could be a Psychological or Psychiatric assessment, a discharge summary from a hospital or hospital diversion program, a discharge summary from a residential setting, the Psychological component of an IEP evaluation, etc. It should contain the clinical information justifying EFT criteria. Information should stress child and family strengths as well as natural supports and resources. If child is placed out-of-home, assessment should detail the family and child needs that must be developed for successful reintegration.
<input type="checkbox"/> Child Behavior Checklist (CBCL)	Completed within 60 days prior to EFT start date.
<input type="checkbox"/> Intake Form – DSM-5 version	
<input type="checkbox"/> IPC with appropriate signatures	<ul style="list-style-type: none"> Dates should match the budget IPC should reflect services in budget
<input type="checkbox"/> Budget Page	Dates should be consistent with the fiscal year. Budget periods should not cross fiscal years. Budgets should be rotated onto a July 1 - December 31 or January 1 - June 30 period whenever possible. Budget should reflect services indicated IPC.
<input type="checkbox"/> DMH EFT Medicaid Deeming Form (Appendix D)	Only needed if child has been determined to be ineligible for Medicaid. Date complete official referral received: _____ Date decision made: _____ Decision approved or denied: _____

Cover Letter

- Client name and DOB
- Summarizes eligibility information
 - Why are you seeking an EFT?
 - What services have you tried or are currently providing?
 - Has the client accessed crisis services? If so, for what reason? Were they screened? Did the client require hospitalization?
 - Is the child at risk of being hospitalized? What evidence supports this?
 - Describe the services being offered.
 - If outside providers are involved, this is the place to describe their role on the treatment team.
- This is the opportunity to justify an EFT. Write it as if an outsider is reading it. Is it clear and does it describe what you are seeking?

SAMPLE

Date

To Whom it may concern (CCM),

The team is requesting an Enhanced Family Treatment Plan for DOB Client is anyear old male/female who attends ...school and is in the ...grade. He/she has a variety of clinically complex needs that have led to this request for additional therapeutic supports in his/her home, community and school.

While at Community House in Brattleboro from ...to ...client was assessed by.....and diagnosed with..... Client has a long history ofresulting in

Child's treatment plan will lay out specifics for family and for client to move toward reunification. The family and child will benefit fromservices.....

Included in the packet are current CBCL assessment, discharge summaries from

Thank you for your time and consideration on this matter. Please feel free to call me with any questions or concerns at

Sincerely,

Who must sign?

- DCF District Director
(only if it's a DCF-matched waiver)
- DA Business Manager
- DA Children's Director
- Parent signature if not on IPC
- If the child turns 18 they must sign the IPC and or signature sheet

APPENDIX C
EFT/Waiver and Individualized Service Budget Signature Sheet - Initial and Renewal

Child Name: _____ Date of birth: _____
 Date submitted: _____ Date determined eligible: _____ Budget period: _____ to: _____
 Submitting Agency: _____
 Address: _____

MSR#: _____ SS#/Medicaid #: _____
 DA/SSA#: _____ DCF#: _____

	Office or Print name	Signature	Date:
DCF	District Office:		
	District Director:		
	Placement Coordinator:		
DA/SSA	DA/SSA:		
	Case Manager:		
	Children's Director:		
	Business Manager:		
Other	Name of Agency:		
	Authorized signature		
Family If not present On treatment plan	Parent(s)/guardian(s):		
	Client (if appropriate)		

DMH Authorization by: _____

Children's MH Care Manager _____

Signature _____

Date _____

Technical Reviewer initials: _____ Date: _____

Procedure code: _____

Daily rate: _____
 DMH or DCF: _____
 Effective date: _____
 Expiration date: _____
 Comments: _____

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Assessments



- A formal assessment done **within 6 months of the EFT start date**. Possible examples include:
 - Psychological or Psychiatric assessment, or
 - Discharge summary from a hospital or hospital diversion program, or
 - Discharge summary from a residential setting, or
 - Psychological components of an IEP evaluation
- It should contain the clinical information justifying EFT criteria.
 - The client's current needs and functioning;
 - Client's skills, resources, and strengths;
 - Level of supports currently available to and needed by the client to function successfully in particular community living, social or work settings.
- Supporting documents can be used to supplement the primary assessment (less than two (2) years old).

CBCL

- The DA/SSA must provide a current (less than 60 days) Child Behavior Checklist (CBCL)
- Indicates significant mental health needs. A syndrome scale or the total score must be in the clinical range in order to meet criteria.
- Submit the **blue form (or copy)** **not** the scored results
- DMH enters data into ADM for aggregate analysis

 Please print **CHILD BEHAVIOR CHECKLIST FOR AGES 6-18** For office use only
ID # _____

CHILD'S FULL NAME First _____ Middle _____ Last _____			PARENTS' USUAL TYPE OF WORK, even if not working now. (Please be specific— for example, auto mechanic, high school teacher, homemaker, laborer, lathe operator, shoe salesman, army sergeant.) FATHER'S TYPE OF WORK _____ MOTHER'S TYPE OF WORK _____		
CHILD'S GENDER <input type="checkbox"/> Boy <input type="checkbox"/> Girl	CHILD'S AGE _____	CHILD'S ETHNIC GROUP OR RACE _____	THIS FORM FILLED OUT BY: (print your full name) _____		
TODAY'S DATE Mo. ____ Day ____ Year ____		CHILD'S BIRTHDATE Mo. ____ Day ____ Year ____	Your gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		
GRADE IN SCHOOL _____	Please fill out this form to reflect your view of the child's behavior even if other people might not agree. Feel free to print additional comments beside each item and in the space provided on page 2. <i>Be sure to answer all items.</i>		Your relation to the child: <input type="checkbox"/> Biological Parent <input type="checkbox"/> Step Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Adoptive Parent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Other (specify) _____		
NOT ATTENDING SCHOOL <input type="checkbox"/>					

I. Please list the sports your child most likes to take part in. For example: swimming, baseball, skating, skate boarding, bike riding, fishing, etc.		Compared to others of the same age, about how much time does he/she spend in each?		Compared to others of the same age, how well does he/she do each one?	
None <input type="checkbox"/>		Less Than Average	Average	More Than Average	Don't Know
a. _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

II. Please list your child's favorite hobbies, activities, and games, other than sports. For example: stamps, dolls, books, piano, crafts, cars, computers, singing, etc. (Do not include listening to radio or TV.)		Compared to others of the same age, about how much time does he/she spend in each?		Compared to others of the same age, how well does he/she do each one?	
None <input type="checkbox"/>		Less Than Average	Average	More Than Average	Don't Know
a. _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

III. Please list any organizations, clubs, teams, or groups your child belongs to.		Compared to others of the same age, how active is he/she in each?	
None <input type="checkbox"/>		Less Active	Average
a. _____		<input type="checkbox"/>	<input type="checkbox"/>
b. _____		<input type="checkbox"/>	<input type="checkbox"/>
c. _____		<input type="checkbox"/>	<input type="checkbox"/>

IV. Please list any jobs or chores your child has. For example: paper route, babysitting, making bed, working in store, etc. (Include both paid and unpaid jobs and chores.)		Compared to others of the same age, how well does he/she carry them out?	
None <input type="checkbox"/>		Below Average	Average
a. _____		<input type="checkbox"/>	<input type="checkbox"/>
b. _____		<input type="checkbox"/>	<input type="checkbox"/>
c. _____		<input type="checkbox"/>	<input type="checkbox"/>

Be sure you answered all items. Then see other side.

Intake form

CHILD AND ADOLESCENT EFT SERVICES INTAKE

I) CHILD INFORMATION

1. Child's Name: _____ 2. Sex: ☐ M ☐ F

3. Birth Date: ____/____/____ 4. Social Security No.: _____-_____-_____

5. Address: _____

6. a. Entitlements: Is the child/adolescent eligible for any of the following entitlements? (*check all that apply*):

☐ No Insurance ☐ SSI ☐ IV-E ☐ Adoption Subsidy
☐ Medicaid ☐ SSDI ☐ Other (specify): _____

Medicaid number: _____

6. b. If not currently enrolled in Medicaid date of application: ____/____/____

7. Private Insurance: _____
(Name of Subscriber) (Company)

8. Legal custody/guardian: _____

Relationship to client: _____

9. Has the child/adolescent been adopted? ☐ Yes ☐ No

For Office Use:

INKS/MCIS No: _____

Record #: _____

Initials: _____

Date entered: _____

II) EDUCATIONAL STATUS

1. IEP Status: (*check one*)

IEP for SED ☐ Need to refer ☐ Unknown
IEP for other reason ☐ Assessed and found ineligible ☐ Not on an IEP
Pending ☐ N/A

2. 504 Status: (*check one*)

504 plan ☐ Need to refer ☐ Unknown
Assessed and found ineligible ☐ Not on an 504
Pending ☐ N/A

III) MENTAL HEALTH AND BEHAVIORAL STATUS

1. DSM-V Diagnoses (Child/Adolescent):

1.a. Primary Diagnostic Code: ____ . ____

1.b. Disorder Description: _____

2.a. Secondary Diagnostic Code: ____ . ____

2.b. Disorder Description: _____

3.a. Tertiary Diagnostic Code: ____ . ____

3.b. Disorder Description: _____

4.a. Diagnostic Code: ____ . ____

4.b. Disorder Description: _____

5.a. Diagnostic Code: ____ . ____

5.b. Disorder Description: _____

Individual Plan of Care (IPC)

- Clinically Relevant goals/objectives
- Adhere to Medicaid quality elements (refer to Medicaid FFS Manual – see Resource list)
- Best Practice (we encourage/don't require)
 - Include all services on IPC, e.g. SB6 & Pvt Insurance, and identify as such (waiver, SB6, Pvt Ins) – use “other funding source” column on EFT budget
 - TFC on IPC if EMR allows, otherwise address in cover letter
- Range of frequency must be within reason (see EFT manual p. 15) and put average frequency on budget
- If your EMR has check-box for frequency to identify Weekly vs. Monthly – check one!

IPC con't

- Services & Frequency must match the budget
- Handwritten changes must be initialed
- Private providers –
 - If a non-DA clinician is providing clinical services concurrent to EFT services, it must be clearly documented that the services are not duplicative to what is included in the EFT/waiver.
 - The IPC can identify that the specific clinical services is provided by a non-DA provider and should indicate coordination of care.
- Consultation: by whom & why?
- E&M (Med Management) (15 min) and Individual Psychotherapy with Medication Management (30, 45, 60 min)



Budget

- **Must match IPC (date range, svc type, frequency)**
- **Use current FY Rate Sheet**
- **Can include non-waiver services by using “Other Funding Source” column on budget**
- **Special Service Funding vs. EFT (e.g. for Consultations/Evals)**
- **Documents should be uploaded to Globalscape (faxes accepted not preferred)**
- **Program Tech, Jessica, can make adjustments to budget, but not to IPC**

Budget con't

*Above/below the line:
what does this mean?*

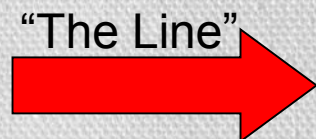
- “**Above the line**” = Medicaid eligible service



- “**Below the line**” = non-Medicaid items such as room & board, personal expenses



Sample budget



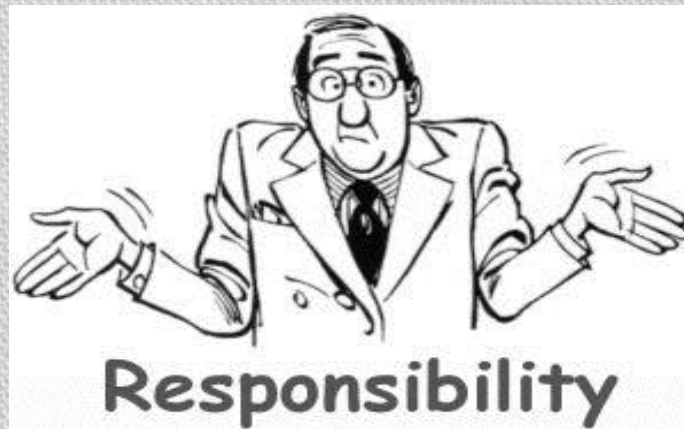
SERVICES BUDGET (DMH Matched Waiver Worksheet) FY15 for budgets between 7/1/14-12/31/14										
LAST NAME: 0		FIRST NAME: 0		MSR CLIENT ID #: 0		MEDICAID (XIX) ELIGIBLE: Y				
DATE OF BIRTH: 1/0/1900				MCIS CHILD #: 0		BUDGET TYPE:				
DATE SUBMITTED: 1/0/1900				CMHC CHILD #:		PERIOD OF THIS BUDGET:				
THERAPEUTIC CASE MANAGER: 0				EFT Applicant DA: 0		NUMBER OF MONTHS:				
HOME CLINIC: 0		SERVICE PROVIDER: 0								
Budget Service Code	Service Description	Provider Agency	CPT	Cost/ Unit	Units Per Week	Units Per Month (x 4.35 weeks per month)	Monthly Total	One-Time Cost	Other	If Other Funding Source/ Contract Name
MEDICAID (XIX) SERVICES										
A01	Service Planning & Coordination	0	T1017	19.98		0.00	0.00			
B01	Individual Community Supports	0	H2017	19.97		0.00	0.00			
B02	Group Community Supports	0	H2014	7.38		0.00	0.00			
E02	Individual Psychotherapy	0	H2019	21.63		0.00	0.00			
E04	Group Psychotherapy	0	H2032	10.02		0.00	0.00			
E03	Family Psychotherapy	0	H2019	21.63		0.00	0.00			
H04	Therapeutic Foster Care	0		DA Fill In		0.00	#VALUE!			
E05	E&M (Med Management)	0	DA Fill In	DA Fill In		0.00	#VALUE!			
E02	Ind. Psychotherapy-Med Eval Mgmt (30min)	0	30833	25.53		0.00	0.00			
E02	Ind. Psychotherapy-Med Eval Mgmt (45min)	0	30836	65.14		0.00	0.00			
E02	Ind. Psychotherapy-Med Eval Mgmt (60min)	0	30838	86.85		0.00	0.00			
G01	Crisis Supports	0		DA Fill In		0.00	#VALUE!			
G01	Crisis Response System	0		4.04		0.00	0.00			
D02	Respite-Overnight	0		DA Fill In		0.00	#VALUE!			
D01	Respite-Hourly	0		DA Fill In		0.00	#VALUE!			
B03	Family Education/Consultation	0		19.97		0.00	0.00			
E01	D&E	0	30791	80.61				0.00		
E01	Psychiatric Assessment	0	30792	83.36				0.00		
MEDICAID SUBTOTAL							#VALUE!	0.00	0.00	
RESIDENTIAL AND OTHER SERVICES PROVIDED BY SUBMITTING AGENCY										
045	Room & Board	0		22.79			0.00			
020	Personal Expense	0		4.16			0.00			
NON-MEDICAID SUBTOTAL							0.00		0.00	
SERVICES NOT PROVIDED BY SUBMITTING AGENCY										
SUBTOTAL							0.00	0.00	0.00	
MONTHLY TOTAL COST							#VALUE!	0.00	0.00	
A. TOTAL TREATMENT (ABOVE THE LINE)				\$ of days	0.00		#VALUE!		0.00	
B. TOTAL BELOW THE LINE							0.00			
C. TOTAL BUDGET ONE TIME EXPENSES								0.00		
D. GRAND BUDGET TOTAL = A + B							#VALUE!		0.00	
WAIVER DAILY RATE (above the line)							#VALUE!			

Budget Revisions – changes as of 7/1/14

- Clinical review of medical necessity and comparison of actual to budgeted service intervention should occur on a regular basis
- Budget adjustments should be made by the last business day of the 5th month in the 6-month budget period (July-Dec; Jan-June)
- Budgets may be adjusted back to the beginning of the 6-month period if necessary.
- If a **new** EFT begins in the 5th or 6th month, revisions to that initial EFT budget may be made up to 45-days past the end of the 6-month budget period (Dec 31st or June 30th).
- Documentation required: Cover letter, budget, signature page, and IPC (if svcs added/removed)

Billing

- You are responsible for
 - ensuring continued Medicaid enrollment;
 - ensuring staff bill under the EFT code;
 - suspensions & terminations.
- Billing a “day of service” includes the day a child/ youth begins the EFT, but not the day they leave the EFT.
- The billing DA is responsible for reporting all MIS info.



Self-Audits

- **As of October 2013 Self Audits are now mandatory for each client's EFT funding**
- Each waiver will be subject to a self-audit by the DA proving the services once per fiscal year. Within 90 days of completion of the waiver period,
- If the self-audit determines that the cost of *actual services* provided by the DA is **within** the allowable error rate of three Percent(3%) of the child's individual EFT budget, no reconciliation is required
- If the self-audit determines that the cost of *actual services* provided by the DA is **in excess** of the allowable error rate of three percent (3%) of the child's individual EFT budget, the DA must refund the full amount of the error.
- If at the end of the original 90 day period, the DA has not completed its self-audit and submitted a report to DMH, the DMH may suspend all Medicaid EFT payments
- DMH may perform an audit on any budget at any time it is determined necessary to verify results of the self-audit and effectiveness of the DA's self-audit process.
- **Please read the Self-Audit section of the manual for a more detailed explanation of the process.**

Respite and DOL/FLSA Rule Changes

- Your agency is responsible to abide by all of the Dept of Labor's Fair Labor Standards Act and the rule changes in effect January 1, 2015.
 - Minimum wage, overtime, travel costs
- EFT Hourly Respite rate ranges already above minimum wage
- DA responsible to manage potential overtime and travel costs
- Overnight Respite – Clarifications
 - Child/youth living in own home (not in custody)
- Therapeutic Foster Care – Clarifications
 - TFC is exempt from these rules
 - Any child/youth in TFC (in custody or not)
 - Primary TFC home and Secondary TFC home. Both homes must be licensed.
 - Child/youth in custody, placed back in own home may have foster home as secondary home.

EFT Overnight Respite Rates

- EFT Overnight Respite rate ranges adjusted to minimum wage
- Assumes 16 hours work in 24-hour period, with 8 hours sleep
- Be aware of DOL rule: **if child needs attention during sleep period, provider must be paid for that time**
- VT minimum wage is \$9.15
- O/N Respite rate range now uses hourly rates: **\$9.15 – \$10.00**
- To calculate Overnight Respite:
 - Determine #hrs per overnight.
 - Select hourly rate from Overnight Respite rate range.
 - Calculate cost of Overnight Respite = #hrs X \$hrly rate.
 - Bottom of Range: $\$9.15 \times 16 \text{ hrs} = \146.40
 - Top of Range: $\$10.00 \times 24 \text{ hrs} = \240

Setting the Rate for Therapeutic Foster Care

The state allows a **range of rates** for TFC. Setting the rate with a prospective foster placement should take into account at least (but not limited to) the following criteria:



- ❖ The child's need for supervision and general risk level
- ❖ The skill level or specific expertise necessary to meet the child and/or family's needs
- ❖ The other services provided to the child that impact the time the TFC provider spends with the child

TFC Rates Continued

In special cases, DMH may approve an increase of the TFC rate of up to 20% if the child exhibits **significant** high risk behaviors. For example:

- **fire-setting**
- **sexual offending**
- **self-harming**
- **aggressive behaviors**

The DA must receive prior approval of this increased rate from their DMH Care Manager before submitting a waiver application.



Termination & Suspension Forms

- Forms located on DMH website

APPENDIX H

**HOME AND COMMUNITY-BASED WAIVER SERVICES
NOTIFICATION OF TERMINATION**

1. Client Name: _____

2. Current Residence: _____

3. Medicaid Number: _____

4. Provider: _____

5. On _____ Home and Community Based Waiver services were terminated
and/or reduced for the above-referenced individual.

6. The reason for termination and/or reduction was _____

ion was not voluntary, the service recipient and guardian must be notified of
attach a copy of the notification that was sent to the service recipient and his

OR

Signature

Date

APPENDIX H

HOME AND COMMUNITY-BASED WAIVER
NOTIFICATION OF SUSPENSION

1. Client Name: _____

2. Current Residence: _____

Address

City/State/Zip

3. Medicaid Number: _____

4. Provider: _____

5. Home and Community Based Waiver services were suspended for the above referenced individual on _____

Date

 Services were resumed on _____

Date

6. The reason for Suspension: _____

7. The maximum length of a suspension is 21 days. Please submit this form as soon as Waiver services resume.

 Signature

 Date

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Medicaid Deeming



Medicaid deeming is a process where DMH can “deem” a child eligible for Medicaid due to their extraordinarily high need for medical coverage of specialized services.

- The child must be clinically eligible for EFT services
- This type of Medicaid can **ONLY** be used for home and community-based services
- While Medicaid deeming does **NOT** take into account the parents’ income or resources, the child by him/herself must meet the income and resources guidelines for Medicaid
- Deeming only lasts for the length of the EFT services, so the family should immediately be supported in applying for “Katie Beckett” Medicaid. This allows Medicaid funding to continue past the waiver, or covers additional services in situations where the child escalates further and needs a higher level of care

EFT and Private Providers:

- If there is a private clinician providing treatment to the client, it can now be billed directly to Medicaid, as long as it does not duplicate a service that is included on a waiver.
- If a treatment team would like this private provider (who is now billing Medicaid directly) to participate in the treatment team meetings, they may, if appropriate, pay that provider for consultation. However, the consultation must then be included on the waiver budget.
- DA/SSA providers cannot bill separately for any clinical Medicaid services provided to an EFT recipient. All DA/SSA mental health Medicaid services must be on the EFT, with the exception of Success Beyond Six Services.
- For children on a Medicaid Waiver, Success Beyond Six Medicaid (or any school based mental health service), may be billed for school supports if:
 - The mental health services are provided in the school environment.
 - Goals and services must be identified in the Individual Plan of Care.



EFT and “Pass-Throughs”

- When EFT services are being provided by more than one DA, we call it a “Pass – Through.”
- When considering a Pass-Through Waiver, teams should discuss who will be the clinical “lead” in directing the treatment, who will be providing the majority of the services, and which agency the child will discharge to. These questions should be used to determine who will be the “lead” DA on the waiver.
- The responsibility for submitting the EFT packet then falls with this lead DA.
- Services can (and often should) be provided by both DA’s. If so, the budget will simply list two lines for each provided service (i.e. two service coordination lines, etc.).
- However, if two DA’s are providing the same service, it is both their responsibilities to ensure there is no duplication in the service being provided, or double-billing for attendance at the same meetings.
- We prefer that there be one combined IPC, but will accept two if necessary.
- The “serving” DA will bill the lead DA for services provided, and the “lead” DA submits the overall bill to HP for reimbursement.
- The DA or any contractor providing the services on the waiver is responsible to provide documentation of treatment services to the lead DA to include in the child’s medical record.

Change in Custody Status

While Receiving EFT Funding

If a child/youth is receiving EFT services and their custodial status changes, the following steps will be taken to determine if and when fiscal responsibility transfers. The following process should be used to determine the date that funding of EFT services changes:

For children in DMH funded placements who enter DCF custody:

- When a child who is receiving EFT Services enters DCF custody, DCF assumes fiscal responsibility on the date the child enters custody.
- Once notified that a child has entered DCF custody, the DA staff must follow the steps outlined in the manual for “Documenting of Fiscal Changes.”

Custody Status Change cont'd

For children in DCF funded placements who have a planned discharge from DCF custody:

- If the discharge from custody is planned, the local team (including at least local DCF, MH, and education), should begin planning for the transition at least **3 months** prior to the custodial transfer.
- If the child will remain in a paid out-of-home placement, then there must also be State DMH approval of the placement, so local teams may need to allow time for that process.
- If DMH approves the placement prior to discharge from custody, then DMH becomes the immediate payee when custody changes.

For children in DCF funded placements who have an unplanned discharge from custody:

- If there is an unplanned discharge from DCF custody while a child/youth is using EFT services and the team wishes to continue with the current plan, DCF and DMH must communicate immediately about the status of the case and need for placement.
- If DMH approves the placement, then fiscal responsibility will transfer from DCF to DMH on the date of discharge from custody.
- Without DMH approval of the funding, the plan is not guaranteed and placement may end.

Suggestions:

- Have a point person to streamline communication with DMH
- If you have different people writing the application than managing/overseeing EFT services, ensure solid communication
- Communicate with your (DA) business office
- Conduct internal technical & clinical review before submitting EFT packets to DMH
- Keep copies of documentation that you submit
- Upload applications to Globalscape. Faxes are accepted, but not preferred. If you upload or fax, don't also mail.
- We are all responsible to uphold HIPAA in our communications, especially via email
- Don't hesitate to call if unsure or have questions!!



In Summary



- Communication with DMH early, before submission of application
- Communication during technical & clinical review
- Goal for all is to process quickly and allow service & billing to begin
- Delays impact DA budget & DMH budget
 - 6-month Medicaid billing window

Resources

- EFT Manual and Forms:
- <http://mentalhealth.vermont.gov/forms>
- Medicaid FFS Regulations/Info:
<http://mentalhealth.vermont.gov/sites/dmh/files/publications>
- Medicaid Fee-For-Service Procedures Manual (2014)
- Medicaid Reference Manual (January 2005)

